Medical Release Form for 4-H Youth & Adults

PARTICIPANT INFORMATION:

Name: _____ County: _____

Address: _____

Name of Parent or Legal Guardian: (YOUTH ONLY): _____

Primary Physician: _____ Phone: _____

Dentist: _____ Phone: _____

IN CASE OF EMERGENCY:

Primary Contact: _____ Phone: _____

Relationship: _____ City: _____ State: _____

Alternate Contact: _____ Phone: _____

Relationship: _____ City: _____ State: _____

INSURANCE INFORMATION

Name of Insurance Carrier: _____

Policy Holder Name: _____ Policy #: _____

Date of Last:

Tetanus Shot: _____ Polio Shot: _____ Mumps Shot: _____ Measles Shot: _____ Rubella Shot: _____

Medical Information: (check all that apply and explain if necessary)

- ☐ Stomach or Intestinal problems
- ☐ Diabetes or hypoglycemia (low blood sugar)
- ☐ Nervous disorder (convulsions, epilepsy, dizziness, ect)
- ☐ Respiratory problems
- ☐ Heart Disease
- ☐ Any allergies to medication
- ☐ Any allergies to food or plants
- ☐ Special diet or food restrictions
- ☐ Are you currently under a doctor's care?
- ☐ Are you currently taking medications?
- ☐ Are there any physical restrictions or medical problems that may require special considerations?

_____

_____

_____

AUTHORIZATION FOR TREATMENT (YOUTH ONLY)

I, _____ do herby give permission to _____

PARENT/GUARDIAN Name — CHAPERONE Name

to seek and obtain any medical care necessary for my child _____.

YOUTH Participant Name

Parent/Guardian Signature _____ Date _____

ALL PARTICIPANTS

To the Best of my knowledge, accurate information has been provided in all areas of this form.

Participant Signature (youth/ adult) _____ Date _____

IF YOUTH: Parent/Guardian Signature _____ Date _____

4-H Camp Medication Form

Please complete this form for all medications your child will be taking.

Child's Name:_____ **County:**_____

Medication Policy

- Youth under 18 years old will not be allowed to keep any medications with them. Exceptions may be made on a case-by-case basis for Counselors to be allowed to self-administer medication with permission of parent/guardian and 4-H Camp Staff. Counselors must have proper storage and show that he/she has the knowledge and skills to safely use the medication.
- All medications must be provided to 4-H Camp Staff at registration in the original container with the child's name printed on the bottle.
- Actual dosage listed on the bottle will be followed unless there is a written note from the prescribing doctor outlining different dosage.
- Please do not supply any over-the-counter medications such as Tylenol, ibuprofen, Benadryl, etc. The 4-H Camp Staff will have basic medications on hand if needed.

Medication Name (include any special instructions)	Dosage	Time(s) Taken

I give permission for the medications listed above to be administered as directed.

Check ☐ Yes ☐ No

Authorized Over-the-Counter Medications:

Please check any medications that can be administered at the age appropriate or weight appropriate dose according to the label during 4-H Camp as needed.

_____ Pain/Fever Reliever (ex. Tylenol)
_____ Antacid
_____ Antibiotic Ointment
_____ Allergy Medication (ex. Benadryl)
_____ Cough Suppressant
_____ Nasal Decongestant
_____ Anti-itch Cream
_____ Ibuprofen

I have read and understand the medication policy stated above and authorize any of the checked medications.

Parent/Guardian Signature:_____ **Date:**_____